

**Stacey J. Nyman MS, NCC, LPC  
Well Being, LLC  
404-368-5552**

Authorization to Release/Obtain Protected Health Information

I, \_\_\_\_\_, authorize Stacey J. Nyman to

Release my records to \_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ and/or to

Obtain my records from \_\_\_\_\_

\_\_\_\_\_

This information should only be released to Stacey J. Nyman MS, NCC, LPC at Well Being, LLC,  
6740 Jamestown Drive, Alpharetta, GA 30005 (Tel. 404-368-5552) for the purpose of coordinating

services. I also hereby authorize Stacey J. Nyman to speak with

\_\_\_\_\_ by telephone as needed to fulfill the purposes of this

release. This authorization shall remain in effect until \_\_\_\_\_.

I understand that I have the right to revoke this authorization by notifying Stacey Nyman in writing at

6740 Jamestown Drive, Alpharetta, GA 30005

My signature below is completely voluntary.

\_\_\_\_\_

Signature of Patient or Authorized Representative Date

\_\_\_\_\_

Printed Name